Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

AUTHORIZATION TO DISCLOSE NON-MEDICAL INDIVIDUAL PERSONAL INFORMATION

Wis. Stat. § 40.07 (1) (a)

IDENTIFICATION OF RECORD:

Participant's (or Alternate Payee's) Name (First, M.I., Last)	
Participant's (or Alternate Payee's) Social Security Number	

I authorize the Wisconsin Department of Employee Trust Funds to disclose non-medical information or records maintained by the Department on the above-named participant (or alternate payee) to the following person(s) upon request:

_____

(Please type or print name of person to whom information may be released)

Individual personal information which may be disclosed under this authorization includes, without limitation, account balances, date of birth, earnings, contributions, interest credits, beneficiary designations, creditable service, marital status, address and Social Security number. However, no medical record, as defined by Wis. Adm. Code § ETF 10.01 (3m), or protected health information, as defined by 45 C.F.R. § 160.103, may be disclosed using this form.

Under Wis. Adm. Code § ETF 10.70 (3) (c), this authorization shall expire six (6) months after the date of my signature below unless sooner revoked in writing or unless another expiration date is expressly stated below:

EXPIRATION DATE (optional):	(MM/DD/CCYY)

SIGN HERE IF AUTHORIZATION IS PERSONALLY GRANTED BY THE NAMED PARTICIPANT, ALTERNATE PAYEE, BENEFICIARY OR NAMED SURVIVOR

The disclosure is authorized from my own record.

Dated this _____ day of _____, _____.

_____
(signature of above-named participant, alternate payee, beneficiary or named survivor.)

I am the:

- ☐ Participant
- ☐ Alternate Payee
- ☐ Beneficiary
- ☐ Named Survivor

Print current address and telephone of person signing above
Telephone: ( )

SIGN HERE IF AUTHORIZATION IS BY A PERSON OTHER THAN THE NAMED PARTICIPANT, ALTERNATE PAYEE, BENEFICIARY OR NAMED SURVIVOR

I certify that I have been duly appointed as the guardian, conservator, executor, or personal representative, of the above-named participant, alternate payee, beneficiary or named survivor or hold an equivalent legal appointment as the participant's representative. (ORIGINAL OR COPY OF LEGAL APPPOINTMENT OR POWER OF ATTORNEY MUST BE ATTACHED OR AUTHORIZATION WILL NOT BE ACCEPTED.)

Dated this _____ day of _____, _____.

_____
(signature of representative)

Print name, address and telephone of person signing above.
Telephone: ( )